A study paper prepared for congregational use by the Division for Church and Society of the Evangelical Lutheran Church in Canada
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OUR RESPONSIBILITY, OUR CHALLENGE

The World Health Organization, in the preamble to its constitution, defines health as "...a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[1]

In a study of health care done for the Lutheran Church in America, Ralph Peterson writes, "Scripture affirms that all human beings are created in God's image. This dignity is the source of the reverence that we have for what is God-like in every human being. Health care is a basic right because it is essential to human dignity."[2] In 1968, the Canadian Parliament passed legislation providing a comprehensive health care system accessible to all Canadians. This health care system is currently being eroded, both intentionally and by neglect. Canada is headed toward a two-tier system, one for those who can pay extra for physician and hospital care, and another which provides minimum services to those who have fewer financial resources. Canadians are being called to take notice and come forward with well-thought-out suggestions for the health care system of the future, in order that all Canadians, no matter what their financial situations, receive the best health care available.

INTRODUCTION

FAITH AND WELL-BEING

Jesus' response to people is often a source of wonder and amazement for me. Following the miraculous event of a blind man restored to seeing after an exchange with Jesus. Jesus could have claimed all the power and glory. He could have said, 'I have made you well. I have restored your vision.' but he didn't. Instead, Jesus said, 'Receive your sight, your faith has made you well.' What a remarkable proclamation, 'your faith has made you well.' Jesus could have said 'I did it all for you.' but instead Jesus chose to say 'we did it together.'

Jesus called the blind man and calls us to use our faith and to act with Jesus in our own well-making and well-being. Jesus calls us away from passivity and toward bold acts of working together."

Eternity for Today, Tuesday, November 23, 1988, Rev. Ruth N. Blaser

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[1]World Health Organization, Constitution, Preamble.

[2]Ralph E. Peterson, A Study of the Healing Church and Its Ministry: The Health Care Apostolate (New York: LCA Division for Mission in North America, 1982), p. 14.

The Board of the Division for Church and Society of the Evangelical Lutheran Church in Canada, at its meeting in September 1986, decided to make health care issues a major focus for the next three years. As a part of that emphasis it presents this paper, Canada's Health Care System - Our Responsibility, Our Challenge, to explore with members of the ELCIC the dynamics of the health care system in our country. Its intent is to call us from our passivity to act wisely and confidently as we face the opportunities, the challenges, and the potential crises before us in health care.

As knowledge and technology in the health care field expand in an economy which is relatively stable, it is necessary that Canadians reconsider our health care options. Every day government officials, health care professionals, and other Canadian citizens make decisions which affect our health care system. The challenge faced by all is to make well-informed decisions based on well-thought-out priorities. We in the ELCIC must establish our priorities for a vision of health care on the firm foundation of the gospel.

This paper is presented as a discussion paper. It first outlines the church's history in providing health care, then it highlights some factors in the ongoing evolution of the Canada health care system. It is intended to encourage us to examine this evolution in the light of our faith and to assess the underlying values which undermine its direction and emphases. Finally, it raises some issues which must be considered as we develop a health care system for the future.

OUR MANDATE

God has blessed us ... with the gift of creation, ... with the gift of Jesus Christ, ... with the gift of life.

The creation with which God blesses us is not a finished product. It is an ongoing, ever-unfolding miracle in which God has invited the whole human family to be co-creators. The healing arts are one way we participate with God in this wondrous process of creation/re-creation. Though we may delegate the administration of services to governments and the dispensation of services to professionals who are trained to meet specific needs, we retain both the rights and the responsibilities of the awe-inspiring gift which is ours.

Jesus came as God's gift to us to bring reconciliation and wholeness, salvation and health, to both sinful individuals and a sinful society. While there are injustices and inequalities in a society, there is no wholeness of health. If we maintain a stance of healthy scepticism in our critique of the health care system, we will recognize that, unless good health care for the middle class is guaranteed, there will not be good health care for the elderly and the poor. Programs for the poor are always poor programs. If we are to keep down the cost of curative health care, we must become serious about programs to reduce poverty, child abuse, spouse battering, abuse of the elderly, and unemployment. Thus, the society requires healing as well as the individual. Jesus, who calls us to participate with him in our own individual well-being, also calls us to be involved actively in achieving wholeness and health in society.

The life with which God blesses us is ours in trust. We must become good stewards of this gift of life. Reflecting critically on our life-styles, we must learn to use resources such as nutrition, exercise, meditation, and a well-cared-for environment. We must learn to focus on well-being rather than on illness. Often we have given the responsibility for health care over to "others," for example, to doctors. We put our trust in the latest technology or drug, rather than assuming responsibility for own well-being and utilizing fully the "physician" within ourselves. It is important that we increase our awareness of, and our reverence for, both our bodies as the dwelling place of God's Spirit of life, and the church, as the body of Christ, for the life with God blesses us is not just individual, it is also corporal and communal. This life together is similarly given us in trust.

Within congregations and with the larger church body, we must explore creative ways in which we can care for one another. Within the society in which we live we must foster nurture of this life. The 1968 social statement of the Lutheran Church in American, the Church and Social Welfare, declares:

"Justice requires that the state promote the general welfare, further the well-being of every citizen, and secure equal opportunity for full development of all its citizens."

We, the people of God, have a collective responsibility to:

"Give justice to the weak and the fatherless; Maintain the right of the afflicted and the destitute; Rescue the weak and the needy" (Psalm 82:3,4).

Thus, as the church, we are both empowered and obliged to call upon municipal, provincial, and federal governments, to fulfil the dispensation of justice which we, as members of society, have entrusted to them. We must guide and correct them as they do so.

It is the intent of this paper to inform and to stimulate us to work towards establishing and maintaining greater justice in health care in Canada. Our health care system is changing and is under increasing pressure to change in order to be more cost-effective. People in the health care professions and outside them are concerned that, as presently organized, the health care system may not be able to provide the best care to Canadians. Both health care professionals and people in government must listen to the ideas and priorities of the people they serve, so that Canadians can devise an exemplary health care system for the future.

BACKGROUND INFORMATION

THE CHURCH'S INVOLVEMENT IN HEALTH CARE

Early History

The Christian church has included healing as part of its ministry since Jesus' time. Wherever Jesus went, people gathered around him and brought their sick for him to heal. In Chapter 5 of Mark, we read how Jesus raised the daughter of Jairus from death. Jairus was a teacher in the synagogue, a man with social standing in the community. The same chapter also relates how Jesus heals a woman with the shameful problem of chronic haemorrhaging. She is considered dirty and unclean and has no social standing.[3] Jesus gave the gift of health to those who needed it, regardless of their standing in the social structure.

When Jesus sent the twelve disciples out into the world, he commanded them not only to preach, but also to "Heal the sick, raise the dead, cleanse lepers, cast out demons.[4] Consistent with Jesus' commandments to his disciples, the church has carried out a healing ministry since its earliest days. In the time of Constantine, in the 4th century, Aesculapia was a temple and a refuge for the sick. In 660 A.D., Bishop Landry founded the Hotel-Dieu of Paris, which continues to this day.[5] During the Crusades, hospitals were founded in London and in Palestine.

In the United States, Lutherans, along with Roman Catholics and Seventh-Day Adventists, have a long history of establishing hospitals. Many of the people cared for in these institutions have been the poor who could not afford private care.[6] In Canada, the Lutheran church began a tradition of caring for the elderly with the founding, in 1926, of St. Paul's Home in Melville, Saskatchewan.

Lutheran Church in America Canada Section (LCA-CS)

[3]Mark 5:21-43, Holy Bible, Revised Standard Version.
[4]Matthew 10:8, Ibid.
[5]James C. McGilvary, The Quest for Health and Wholeness (Tubigen: German Institute for Medical Mission, 1981), p. 1-2.
[6]Peterson, p. 17.

The Lutheran Church in America and the Lutheran Church in America-Canada Section have had a history of being concerned with health care policy and advocating for access to health care for everyone, regardless of income or social standing. In September 1967, a study report entitled "A Health Charter for Canada - A Concern of the Church" was issued by the LCA-CS. The study draws and highlights the findings of the Royal Commission on Health Services, also known as the Hall Commission Report, 1964.[7] In response to the study paper, the Fourth Biennial Convention of the LCA-CS adopted the social statement, "Towards Adequate Health Care for All Canadians." The statement quotes the Charter of the World Health Organization, to which Canada is a signatory:

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions."[8]

The social statement commends the federal government for the enactment of the Medical Care Act of 1966. It then states a further eleven concerns which need to be addressed to make the health care system more available to all who need care, more concerned with promoting health, and more inclusive of all health care personnel, not just physician care.

In 1982, the LCA published "A Study of the Healing Church and Its Ministry: The Health Care Apostolate." This study was prepared by Pastor Ralph E. Peterson as part of a directive by the 1980 convention of the LCA that the church take seriously its responsibilities to participate in the exciting new advances in health care policies and practices."[9] The twenty-nine-page study provides a biblical and historical perspective for today's church to be involved in health care; it identifies the myths surrounding religion and medicine; and it affirms health care as a ministry for the church, as Christian stewardship, as a means of service, and as a witness in the public arena.

The Evangelical Lutheran Church of Canada (ELCC)

The Evangelical Lutheran Church of Canada found a role in health care by providing facilities for direct care, particularly care for the elderly. Homes and hospital facilities were founded in various locations in western Canada to provide personal care to residents.

Increasingly, the concern of people working in these facilities has broadened
to include services to enable people to remain in their own homes. The Good Samaritan Society of Edmonton. Alberta is an example of a facility which provides a variety of services both to residents and to people living in the community who need some help to maintain independent living.[10]

The administrator of St. Paul Lutheran Home, Melville, in his 1982 preconvention report, notes that one task facing the personnel of the home, and presumably Lutherans in general, is to challenge and change public attitudes on aging. He continues, "... the board and staff must find new and creative ways to function interdependently in the great mission of proving services to the elderly.... We must challenge and confront society, corporations, boards, staff, and the elderly themselves regarding institutional living and growing old."[11]

This challenge to advocate for quality of life for the elderly is ongoing. It includes reviewing and refocusing our health care system so that it is relevant to the needs of all segments of society.

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[7]Lutheran Church in America - Canada Section, Continuing Committee on Social Issues and Concerns, A Health Charter for the Canada - A Concern for the Church (Toronto: LCA-Canada Section, September 1967).

[8]Lutheran Church in America - Canada Section, Towards Adequate Health Care for all Canadians. Social statement adopted in Edmonton, Alberta, June 23-25, 1969, p. 5.

[9]Peterson, p. 1.

[10]George Henning, "A Look at the Good Samaritan Society," The Pulse, 1, 2, Spring, 1986, p. 3.

[11]Donald Whittmire, ELCC Preconvention Report, 1982, p. 129.

HISTORY OF THE HEALTH CARE SYSTEM IN CANADA

The health care system in Canada has taken a different road from that in the United States since World War II. In 1944, the Cooperative Commonwealth Federation party (CCF), under the leadership of Tommy Douglas, became the provincial government in Saskatchewan. The main planks in its platform were "security on the farm, in the job, in the family, and adequate health care."[12]

Coverage for hospital charges began in 1947 under the Saskatchewan Health Services Act. In the early 1950s, the CCF government began working on a Medicare plan to cover medical costs. The bill establishing Medicare was passed by the Saskatchewan legislature on November 18, 1961, with its start-up date July 1, 1962.[13]

British Columbia and Alberta passed legislation to cover costs of hospital care in 1949.[14] The federal government of Prime Minister St. Laurent passed the Hospital Insurance Diagnostic Services Act in June of 1957. This legislation promised that, as soon as six provinces representing the majority of the population passed enabling legislation, the federal government would pay half of hospital costs. People enroled in the program, would be entitled to standard ward care, diagnostic, laboratory, and x-ray services, and drugs while in hospital.[15] The next federal government, under Prime Minister Diefenbaker, waived the stipulation of six provinces having to pass enabling legislation before the federal government would assist with hospital charges. As a result, five provinces received federal government money to help pay hospital costs in 1959. By 1969, all provinces had signed up for hospital insurance.[16]

In 1959 the federal government appointed Chief Justice Emmett M. Hall to chair a Royal Commission on Health Services. A number of research studies were commissioned to gain information concerning health care personnel and trends in health care. In his final report, A Charter of Health for Canadians, tabled in 1964, Hall outlined six principles which should guide health care planning in Canada. These are:

1. *Universality* - 100% of qualified residents of a province would be covered by health insurance.

2. *Comprehensiveness* - A range of ? must be provided on an insured basis.

3. *Accessibility* - all residents of Canada should have reasonable access to insured services both quantity and quality.

4. *Portability* - residents of Canada should be able to travel anywhere in the world or relocate anywhere in Canada without forfeiting their entitlement to insured services.

5. *Public administration* - insured services should be administered on a non-profit basis by a public authority appointed and designated by the province.

6. *Uniform terms and conditions* - insured services are not to be restricted based on age, health problem, sex, ethnic group, income status, or citizenship.[17]

To date, the principle of Universality has been fairly well implemented. Three provinces charge premiums which could be a problem for some residents to pay. In fact, one province tried to disqualify residents who did not pay their health insurance premium, but it met with such strong opposition that it backed

[12]Tommy Douglas, "The Radical Gospel," Saturday Night, 102, 1, January, 1987, p. 138.
[13]J.L. Granatstein, Canada 1957-1967, The Years of Uncertainty and Innovation (Toronto: McClelland and Stewart, 1986), pp. 171-181.
[14]Ibid., p. 171.
[15] J.M.S. Careless and R. Craig Brown, The Canadians 1867-1967 (Toronto: Macmillan of Canada, 1967), p. 750.
[16] Granatstein, p. 172.
[17] Monique Begin, Canada, Department of Health and Welfare, "White Paper - Draft 2, September 29, 1982," To the Provincial Ministers of Health, unpublished.

down. The principle of comprehensiveness has never been fully implemented because the physician was the gatekeeper of the system and the only health care professional paid directly by the insurance plan on a fee-for-service basis. This has led to less-than-optimal use of the skills and knowledge of other health care professionals such as nurses, dietitians, and physiotherapists. The other principles outlined by Mr. Justice Hall have been only partially implemented as well. In fact, one province has hired a private company to administer several hospitals in the province on a profit basis, a step directly away from the principle of public administration.

In Saskatchewan, the 1964 election saw the defeat of the CCF government. Key civil servants looked for positions elsewhere and found them in the Pearson government in Ottawa. Prime Minister Pearson and others in his government were interested in Medicare and the Saskatchewan experience with it. Al Johnson, who had been the Deputy Provincial Treasurer in Saskatchewan, became a key person in the redrafting of proposals for federal Medicare legislation. He laid out four principles which were accepted by the Pearson government as necessary for federal support for provincial government Medicare programs. These principles were:

"Coverage was to be comprehensive and extend to virtually all physicians' services; the plan had to be universal in coverage; the provinces had to take responsibility for the administration of their plans; and benefits had to be portable."[18]

The proposed federal Medicare legislation was discussed at a federal-provincial conference on July 19, 1965. The government brought the bill to the House of Commons on July 12, 1966. It was passed in December 1966, and went into effect on July 1, 1968. British Columbia and Saskatchewan, provinces that already satisfied the four federal principles, immediately qualified to receive half the costs of their provincial Medicare plans from the federal government. It took until the beginning of the 1970s for all ten provinces to qualify.[19]

Health care came to the forefront of political discussion again in the early 1980s as the Canada Health Act was brought before parliament. Vigorous debate surrounded it as some groups argued that health care spending was getting out of control while others argued that the health care system was under-funded. Across Canada, between twenty and thirty-five percent of principal spending was on health care in 1980-81.[20] In light of his previous work on the subject, Mr. Justice Emmett M. Hall was asked to again study the health care system in Canada.

The Canadian Nurses' Association, in its brief to the Health Services Review, made a number of recommendations which suggested a change in focus for the health care system from a curative/hospital-centred system to one focused more on health promotion and disease prevention. The recommendations also suggested that people be permitted to utilize the services of health care personnel other than physicians when their services would be more appropriate.[21] The Health Services Review accepted the CNA recommendations.

The Canada Health Act was proclaimed April 1, 1984. Section 9 reads: "In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all health services provided by hospitals, medical practitioners, or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners."[22] Section 2 of the Act includes

[18] Granatstein, p. 195.
[19] Ibid., pp. 195-197.
[20] Canada, Department of Health and Welfare, Preserving Universal Medicare (Ottawa Canada, Department of Health and Welfare, 1983), p. 15.
[21] Canadian Nurses' Assocation, "Putting 'Health' into Health Care," Submission to the Health Services Review '79 (Ottawa: Canadian Nurses' Association, February, 1980), pp. i-iii.
[22] "Canada Health Act 'We've Won," Canadian Nurse, 80, 5, May, 1984, p. 7.

the following definition of "health care practitioner": "A person lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person."[23]

Sections 2 and 9 provide provinces with the opportunity to refocus their health care system from a curative/hospital- and physician-based system to one that promotes the appropriate use of other health care personnel and community settings. For example, when a person needs help with nutritional needs, he/she should see a dietitian. A physiotherapist is the appropriate person for many musculoskeletal problems. A nurse can effectively monitor stable chronic illnesses, provide immunizations, and give advice regarding well children as well as counsel regarding health lifestyles.

Since the passage of the Canada Health Act in 1984, there are all sorts of new possibilities for health care in Canada that could help us use our present health care money more effectively, but Canadians will have to speak out to overcome structural paralysis if change is to happen. To date, none of the provinces have moved to change their health care legislation to implement a refocused health care system.

Money for health care comes from both federal and provincial governments. Over the years there have been discussions between federal and provincial departments of health concerning how money from the federal government is allocated to provinces and how that money is spent by the provinces. Fiscal arrangements began changing in the mid 1970s, from the federal government sharing half of hospital and physician care costs to one of a block sum of money being given to each province to spend as it wishes to provide health care. This change gave the federal government more control over its spending and provided the provinces more flexibility in health care programming. However, the provinces have been slow to implement changes in health care delivery. By assisting provinces with health care costs through block funding, the federal government lost its leverage in promoting the basic principles of health care as outlined in the Charter of Health for Canadians.[24] The Canada Health Act of 1984 shows leadership, but the individual provinces must now change their legislation and refocus their health care systems to implement the new possibilities for health care. In each province, individuals and groups concerned about health care must work to implement changes in provincial legislation in order to better utilize health care funds and personnel.

Two recent developments in Canadian federal politics threaten to undermine significantly the Canada health care system as we know it. The Meech Lake Accord, which affirms the existence of each province as a distinct society, may mark the end of the federal principle of national collective decision-making for the common good. It may no longer be possible for the federal government to attempt to ensure that there will be equal implementation of a health care system across this country. Similarly, the Free Trade Agreement with the United States of America could be a distinct threat to our health care system. Health care, because it is not specifically mentioned in this agreement, is therefore not exempt from it. Although politicians assure the Canadian people that our Medicare system will remain intact, as American profit-making corporations enter the Canadian health care field, a two-tier health care system may evolve in this country, with one level of service for those who can afford to pay user fees and another for those who cannot. Please refer to Appendix A - Political Threats to the Canada Health Care System, prepared by Pastor Clifton Monk, for further study of these important issues.

HOW HEALTH CARE IS DELIVERED NOW

Canada has a health care system which is good at meeting the challenges of crisis and illness. People who would have died twenty years ago are alive today thanks to advances in knowledge, medication, and technology. Training in cardiopulmonary resuscitation, the use of cardiac monitors, and new medications have saved the lives of many people who have had heart attacks. Advances in neurosurgery have saved accident victims. New knowledge and technology in the field of neonatology have enabled low birth-weight infants and those with birth defects to survive and to do so with fewer handicaps.

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[23] Ibid., p. 7.

[24] Registered Nurses' Association of Ontario, draft of "Background Paper on Established Programs Financing." Toronto, Registered Nurses' Association of Ontario, 1986, unpublished pp. 3-6.

Despite the advances of our health care system, it retains its negative focus on illness, rather than developing a positive focus on well-being. It lags behind our knowledge and understanding in the areas of nutrition, exercise, mental health, accident prevention, and environmental health concerns in general and, more specifically, in the workplace.

In 1979, the federal government published a working document by the then Minister of Health, Marc Lalonde. Entitled A New Perspective on the Health of Canadians, it advocated a broader definition of health care thana the current illness-crisis-oriented system.[25] Lalonde advocated some progressive ideas regarding spending on health promotion and illness prevention, yet, in the 1980s, ours is still an illness-focused system. Based on preliminary figures, 8.48% of the Gross National Product (GNP) of Canada was spent on health in 1985. This was down from 8.67% of the GNP in 1983. Of the $39.3 billion spent on health care in 1985, $15.9 billion went towards hospital care excluding capital costs; $203 million went towards home care; $1.7 billion towards public health. These figures translate into $1,543.26 per person on health care in 1985; $626.96 towards hospital care, $8.02 towards home care, and $66.65 towards public health.[26] Tables 1 and 2 show how these figures change from 1975 to 1985. There has been movement toward more money for public health and home care, but these aspects of health care have traditionally had so much less money than hospital care that increased emphasis will have to be put on financing these services in the future if health care spending is going to be put into balance.

Provincial governments voice their interest in changing the health care system from one focusing on curing illness to promoting health, yet the money spent on community health services lags far behind that spent on physician fees and hospital costs. National patterns of spending on health care are reflected by the province. For example, Ontario, in the last decade allocated only 3.13% of the total Ministry of Health budget to public and community health programs.[27] Public Health expenditures, as a portion of the total Ministry of Health budget, have increased by 256% in the same period.[28] In Newfoundland, total expenditures for health care increased 151.54% from 1981 to 1985. Public health expenditures went from 3.76% of the 1981 budget to 3.53% of the 1985 budget, although the dollar amount did increase.[29] It becomes apparent in looking at health care spending that, in spite of what is said about the importance of programming for health maintenance and illness prevention, most health care money is spent on curing illnesses and injuries. Decisions concerning expenditures on health care are being based more on consideration of what is needed to maintain the economic structure of the existing system than of what will contribute most in the long run to individual and community well-being.

The assumption underlying health care financing when the system was started was that Canada would enjoy an ever-expanding economy. The difference in the sizes of pieces of pie is not as noticeable if everyone gets a bigger piece as the pie gets bigger. Today the economy is not expanding as rapidly as it once did, and therefore, the size of the pie, which is divided between hospital and physician care costs and the cost of community based care, is not increasing. To gain money for health promotion and illness prevention, Canadian must consider the possibility of cutting the pie differently.

ISSUES FOR THE FUTURE

THE NEED FOR A CHANGE IN FOCUS

Technology

[25]Marc Lalande, A New Perspective on the Health of Canadians: A Working Document (Ottawa: Canada, Department of Health and Welfare, 1974).

[26]Canada, Department of Health and Welfare, Prepublication Tables for the report: National Health Expenditures in Canada, 1975-1985.

[27]Ontario Nurses' Association, "Caring for the Elderly," Position Paper Number Five (Toronto: Ontario Nurses' Association, February, 1986), p. 2.

[28]Ontario Nurses' Association, "Perspectives on Health Education," Position Paper Number Three (Toronto: Ontario Nurses' Association, December, 1985), p. 1.

[29]Letter from Acting Director, Government of Newfoundland and Labrador Department of Health, March 25, 1987.

Technology has changed the health care system over the years and is doing so at an increasing pace. Various kinds of medications and hardware, such as CT scanners, are playing expanding roles in treating and diagnosing illnesses. It is natural to want the most up-to-date care when one is ill. Doctors are using all this technology to provide good care. However, because of the monetary and human costs. Canadians need to take stock of the technology which is available now and that which is to come in the future and to decide on some rationalization for use.

Some questions which need answers are: What drugs and how many drugs are actually effective? How much money should be spent on hardware, such as CT scanners, in order to obtain the newest technology? From where will funding for this come? Should all hospitals have this high-tech or just some of them? Which patients will benefit from the newest technology? What provisions will be made for training and for maintaining the expertise needed to operate equipment and to interpret the information given by this technology?

For Discussion:

- People who are not health care professionals often feel unqualified to discuss scientific and technological questions such as those raised in the last paragraph. Give some suggestions as to how such people could come to be more comfortable talking about these items.

- What important contributions could people outside the health care professions bring to discussions of the technological and scientific issues in health care?

Specialization and Depersonalization

As the body of our scientific and technological knowledge has increased, so has the degree of specialization within the health care professions. This has led to mystique surrounding highly-skilled professionals and has contributed to the perception which many patients have of being depersonalized and compartmentalized. People tend to feel vulnerable when the state of their health is at issue. Often they are fearful from a lack of understanding as to what is happening to their bodies. It is difficult to trust something as personal as one's very being to a stranger. When a person waits for several months for an appointment to see a specialist for a few brief minutes, it is not easy to be convinced that the doctor either knows, or cares, who you really are. A sense of personal relationship is missing. Indeed, when one feels oneself to be perceived as but a heart, kidney, sinus, hand, wart, or phobia, it is heard to maintain a realistic sense of wholeness. Even the general practitioner, now often functioning more as a referral mechanism than as a coordinating, unifying force, has contributed to this fragmentation.

Story #1: Just A Finger

> Pastor S. recently had a joint replaced in the little finger of his left hand. He recognizes that this is not a serious health problem, but as he is left-handed and he had suffered considerable pain and immobility from the previous broken joint, he is hopeful that this operation will restore his hand to a reasonable state of normalcy.
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> Before the operation, his general practitioner had referred him to Dr. R., the chief specialist in the area of hands at a plastics clinic in a major teaching hospital. Dr. R.'s secretary informed Pastor S. that he could have an appointment to see the doctor in two months in a consultation setting with other doctors (residents studying plastics). To see the doctor in his office would require a wait of four to six months. Pastor S., considering his need to deal quickly with the knife-like pain which continually shot up his arm, chose the former.
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> Consultation day arrived. Dr. R. and his residents saw Pastor S. for approximately five minutes, during which Dr. R., using the pastor's finger as a specimen, discussed "the case" with his students,

who checked out "the example" while the doctor spoke. Then the professionals moved on. Pastor S. had almost no time to talk to Dr. R.

Four months after this encounter, Pastor S. received notice that the operation was scheduled two weeks hence. He saw one of the residents briefly before the general anaesthetic took effect. Though he assumes that Dr. R. was present at his operation, Pastor S. did not see him then.

Released from the hospital twenty-four hours after his surgery, Pastor S. dutifully appeared at the plastics clinic one week later. After several residents assessed the state of the finger, Dr. R. appeared for perhaps forty-five seconds, uttered an affirmative comment, and left.

A week later, yet another resident removed Pastor St.'s stitches and referred him to both Occupational Therapy and Physiotherapy. Unfortunately, the advice given by each of these disciplines contradicted the other. Pastor S. chose the course which seemed most logical to him. He hopes that he has made the right choice. His next appointment at the plastics clinic is set for two months from his last visit. Dr. R. may, or may not, be there.

This experience has been educational. Pastor S. has very mixed feelings. He is grateful to live in a country where medical and hospital services are provided, for he knows that he could not afford the cost of such surgery. At the same time he feels frustrated and angry at the lack of information he has received and at the lack of concern shown him as a person.

Pastor S. wonders how people whose problems are more serious than his can cope with such a system.

For Discussion:

- Share experiences about times and places in which the health care system has, or has not, met both your personal and medical needs. Talk about how you felt and the effect these experiences had on you.

- Imagine ways that our health care system could provide the ultimate in medical science and technology and ensure that a patient's personal needs are met.

- How can our church, individually and collectively, contribute to the process of re-humanizing health care?

Lifestyle

A system focused on curing illness is not necessarily appropriate for today, when many illnesses are lifestyle-engendered. A person can receive publicly-funded care in a hospital for lung cancer, but must pay if he or she wants to attend a clinic to get help to stop smoking.

"Thirty percent of heart disease can be attributed to smoking, the single most preventable factor in heart disease and stroke," says Dr. Anthony F. Graham, president, Heart and Stroke Foundation of Ontario.[30] Yet tobacco companies may still advertise their products, and the use of smokeless tobacco products ie even increasing.[31] The portrayed image of wealth and sophistication associated with these products has been accepted by many consumers.

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[30]Anthony F. Graham, quoted in "Daily Bulletin," For Frances Times, January 15, 1987, p. 9.

[31]Loris J. Miller, "Smokeless Tobacco: An Emerging Health Threat for Canadian Youth," Canadian Nurse, 83, 1, January, 1987, p. 14.

Our cars and push-button conveniences have led to sedentary lifestyles for many Canadians. Exercise has become something we have to do intentionally. Easy-to-chew, always available, empty foods such as candy, potato chips, and pop form a large part of the diet of many people. Good nutritious foods are available, yet many people choose to open a plastic wrapper rather than eat an apple. Lack of exercise and poor nutrition are often the cause of lack of energy and enthusiasm for life, which can make people vulnerable to infectious illness and accidents.

Story #2: A Living Faith

Nancy L. was in her mid-thirties. She was overweight and out-of-shape. Her self-image was at an all-time low. She had to do something, but she knew that appearing in a leotard at the local exercise class, which was full of sweet, svelte, young things, would only vaporize the modicum of self-confidence that she had left, and would probably set her off on a chocolate truffle binge. Nancy approached the problem in her usual manner. She prayed.

Over the next few weeks Nancy began to notice that many of her friends and neighbours were also somewhat less than fit. She rightly surmised that they, too, were unenthusiastic about the existing fitness class. It was intimidating and it was far enough away to make it difficult to get out. She realized, as well, that those with two or three preschool children and no care would find it impossible to attend any class regularly, especially in winter.

Nancy thought, then prayed, then formulated a plan, then she prayed some more. Finally, she summoned up all her courage and went downtown to the Y.M.C.A., where she enroled in a training course for fitness instructors. She felt very self-conscious. She didn't conform to the stereotype of a potential Jane Fonda, and as she looked around it seemed to her that everyone else did. But, Nancy had an answer to her prayer. She knew that her own greatest burden was also her own greatest strength. What she needed, what her neighbourhood needed, was an overweight, out-of-shape, nonetheless full-qualified and unintimidating fitness instructor. Nancy successfully completed her training course and she became just that.

Approaching her pastor, Nancy arranged to book the church basement three times per week when it wasn't in use. Together they dug out some old tumbling mats left behind by a long-since defunct Boy Scout troop, and they got permission to use them. Nancy charged a modest fee per session, and whatever proceeds there were, she donated to the church.

Once the snow flew, Nancy began making the rounds several times per week with in-home classes for her neighbours who were housebound with little tots.

Everyone's well-being flourished. Everyone's self-image improved. The social interaction was a spin-off. People came to know and to care for their neighbours. The well-being of the neighbourhood prospered. A sense of community grew.

Nancy knows a lot about healing.

For Discussion:

- Nancy creatively used her strengths and her weaknesses to increase the well-being of herself and her neighbourhood. Share stories about the "Nancies" you may know. What can we learn from them?

- Talk about creative ways in which we might positively affect our own well-being and that of our communities.

- The Canada health care system exists because concerned individuals took creative steps earlier in this century to ensure that medical and hospital services might be available for all. Imagine ways in which our current governments might encourage and affirm healthy lifestyles.

Disability or Differing Ability

Many people today, young and old, are living with chronic illness or disability. Our health care system, as it is currently designed, is excellent in meeting acute and short-term crises, but it is deficient in the ability to follow through in helping people with ongoing needs. Community care resources such as day care, respite care, home nursing visits, and physiotherapy outside of a hospital are not readily available or are available only for a very limited time. More education for society regarding the disabled, as well as healthy lifestyle promotion for the disabled, would help to integrate our differently disabled brothers and sisters into society so that their talents and abilities may be more fully realized.

The strain on families with severely or multiply handicapped children can be debilitating. Even with the help of care workers, teacher's aides, and respite care, the task can be draining - and that help is far from universally available. Across Canada there is inequality between the provinces in the services and equipment which they provide to the disabled and their families. The only consistency seems to be that this is a time of cutbacks, of reduction rather than expansion of services.

Story #3: Necessary Supports for Independent Living

In Manitoba, Linda is a single parent, the mother of Kim, who has cerebral palsy. Linda points to the adaptive equipment needed to support her daughter - in her wheelchair, at the table, in the bathroom. This equipment must be replaced or adjusted as Kim grows.

The provincial government, through its Rehabilitation Centre for Children, has always custom made the adaptive equipment which Kim needs to thrive. However, a recent policy change states that, if equipment is anywhere commercially available, parents must now assume responsibility for buying it. Linda wonders how, on a limited income, she will be able to afford this change. The equipment is very expensive.

Linda is aware, however, of how fortunate she has been to date. She recalls, while travelling in the Maritimes, visiting John, a twelve year old boy who, like Kim, has cerebral palsy. His only support at the table was a child restraint car seat. The only other equipment available to him as a piece of foam on which to lie. He was the size of six-year old, not because of cerebral palsy, but rather as the result of a growth deformity, a severe curvature of the spine resulting from inadequate support. John's parents have not been made aware of what adaptive equipment might be available for their son. Even if they were informed, the issue is almost academic, because in their province a fee is assessed for adaptive equipment. John's parents, though working, are poor. Perhaps if they knew what to ask for, they might be able to approach a service club for help. But when? His mom works seven to three. His dad has the four to midnight shift. They spell each other off caring for John and his brothers and sister. Just keeping up with the meals, the laundry, and the basic housework has worn them down. They barely have the energy to be kind to one another.

For Discussion:

- Imagine what would be needed to provide an equal and just health care system across this great country of ours. Talk especially about ways that we might ensure that the "least" of our brothers and sisters would not be overlooked.

- Look close to home. Talk about accessibility for the disabled in your church and in your neighbourhood.

Canada's Aging Population

The Canadian population is aging and doing so quickly. The first bulge in the age group sixty-five and over will show up before the year two thousand.[32] Older people are not universally ill; however, many do have some limitations due to chronic illness. The present health care system, with its emphasis on acute and crisis situations, is not appropriate to the needs of this population group. A system of care which could provide easy monitoring of illness, such as heart disease, to note changes early and to prevent acute illness, would serve both the individual and the taxpayer. Community health centres, where people have ready access to a variety of health care professionals, could provide preventive care.

Canadians have a comparatively high rate of institutionalizing elderly people. 9.45 percent of the Canadian population aged sixty-five and over is in institutional care. This contrasts with 5 percent in the United Kingdom and 5.3 percent in the United States.[33] A higher rate of institutionalization may be necessary in Canada, given the relatively small population spread over a large geographic area and the consequent difficulty in delivering home services. However, it is time to examine this course of care to be sure that it is the best care possible, given that it is costly in terms of life satisfaction and money.[34]

Story #4: More Than LEFSA

> Mr N. will be ninety next month. Since his wife died several years back, he has lived in a residence, really just a dormitory, for the elderly. He has only a single room, but it does have a sink, although the toilet and shower facilities are down the hall and must be shared. Linen services is provided. He takes most of his meals at the cafeteria downstairs, but, although it is against the rules, he has smuggled in a hot plate; occasionally, whenever he can make it down to the supermarket a block away, he treats himself to something "home-cooked."
>
> Mr. N. has trouble with his hip, and although he uses a cane he is still unsteady on his feet. His vision is poor due to cataracts. Nonetheless, an operation has given him some use of one eye, "so it's better than it was."
>
> You used to be able to see Mr. N. at the ELW social gatherings at the church. He used to bring another old gentleman, who he introduced to the delights of lefsa and krumkake, like his wife used to make. Now his friend has died, and even if Mr. N. could make it to the church, he can no longer negotiate the stairs. The pastor's wife sends over a nice tray of goodies at Christmas time, but although it is kind of her, she is not Norwegian; it isn't really the same.
>
> Mr. N. has no family. The "young" couple who used to look out for him are now in their late seventies and their health is failing.
>
> Mr. N. is a "fighter". He's not really ready to die, but there is not much left to live for. In every way he can he fights the depersonalization of the institution and the society in which he lives. He rather hopes that he will die soon, for, although his mind is alert, if his physical abilities fail any more, he won't be able to resist much longer.

For Discussion:

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[32]Woods Gordon Report to the Task Force on the Allocation of Health Care Resources, "Investigation of the Impact of Demographic Change on the Health Care System in Canada," August, 1984, p.v.

[33] Task Force on the Allocation of Health Care Resources, Health A Need for Redirection, 1985, p. 25.

[34] Ibid., p. 26.

- Mr. N. has lived ninety years and his mind is still alert. What can we learn from him? If we can find a way for Mr. N. to share with us the resources of his fighting spirit, will we not also provide him with a reason to live until he dies?

- What is quality of life? Is it clean linen and three square meals a day? What is it, besides lefsa, that's missing for Mr. N.?

- How do we deal with dying in our society? Do we know how to be really present with Mr. N. as he passes from this life to the next? What can we do to ensure that this grand old man, and others like him, can exit this life with as much dignity as they have lived it?

As the number of elderly increases, the costs of proving health care to them will increase. An increase in home support services such as "meals on wheels", home care, day care, and housekeeping services would make it possible for people to stay in their homes longer or for family to care for an ill member at home. These services are less costly per individual cared-for then institutional care, and lead to increased life satisfaction.

In the past, these services have been provided by small amounts of provincial government money, unpaid volunteers, community service groups, or they have been paid for by the person receiving the service. It is not inappropriate for volunteers and community service groups to help others in this way, but more financial commitment from the provincial health care budgets is in order. Our present health care system protects people from the devastating effect of a big bill for an acute illness involving hospitalization. It can be just as devastating to be faced with a long, slow drain on the finances from an ongoing illness, a drain which our present system is less able to prevent.

Story #5: A Home of One's Own

Mrs. R. is in her eighties. She suffers chronically from arthritis and emphysema. Her husband of more than fifty years died seven years ago. They had no children. She lives alone in the little house which they bought in the 1940s for five thousand dollars. She keeps the house as neat as a pin.

As her only sources of income are her old age pension and the guaranteed income supplement, she uses the produce from her vegetable plot to help see her through.

It takes every penny of her modest income to maintain the house. Last year the old furnace had to be replaced. Two weeks ago the hot water pipes sprang a leak.

Mrs. R. can no longer keep up with mowing the grass and shovelling the snow, but she doesn't want to give up her home. Although it would not sell for much, the monetary "capital gain" would cause her to forfeit her income supplement until all the capital was gone. She fears that then she would have no security, nothing to fall back on.

More than that, however, she fears having to live in one room and not being able to get outdoors. She says, "We lived in one room in a house in the thirties, when my husband was on relief. Because we had no children, we weren't entitled to more than that. We worked so hard for this. I think I'd die if I had to live in one room again."

For Discussion:

- Study after study has proven that it is more cost-effective and provides much greater satisfaction with quality of life for Mrs. R. and others like her to continue to live in their own homes. Talk about the obstacles to providing support for this lifestyle for our senior population. Give your suggestions as to how they might be overcome.

Story #6: All Alone At The End

Mrs. L. was eight-six in February. As the result of a stroke she was rather feeble. She couldn't get about too well. Her eyesight was poor and getting worse. She was mildly confused and her short-term memory was deteriorating. You'd start out having a conversation with her, but after a minute or two she'd sort of fade away, often lapsing into the Norwegian of her girlhood. Because of this, several years ago, her only son took steps to become her legal guardian. He took control of her financial affairs.

To help with her mobility and awareness, three mornings per week Mrs. L. attended a provincially-funded geriatric day program at a local community hospital.

She lived in a seniors' apartment block run by a local Lutheran Service Club. Increasingly, the administrator of the block became concerned for Mrs. L's safety and that of other residents, as it became known that Mrs. L would frequently turn on stove burners or plug in her iron, and then, forgetting what she had started, she'd take a nap. More and more protective and unsure of herself, Mrs. L. would bolt and chain the door to her apartment. Several times she fell, hurt herself, and could not get up. But although residents could hear her moaning, even the administrator, with a key, could not get in to help her.

Although the administrator tried to convince him, Mrs. L's son was not interested in assuming any more responsibility for his mother. He said that he didn't have the time and he certainly couldn't entertain the idea of having her move in with his family.

Members of Mrs. L's home congregation also tried to talk to her son. He told them to "butt out," and that all of his life he had put up with her way of doing things and how she'd have to put up with his.

The workers at the hospital's geriatric day program tried to convince Mrs. L's son of the necessity of finding her a place in a nursing home. He refused. He openly stated that it wasn't worth the money. He was not going to "waste" his inheritance maintaining her.

Last month, alone in her apartment moaning for help, with the administrator and residents trying to break in, Mrs. L. died. Her son opted to have "the body" cremated. Because it didn't cost anything, he did allow the church to hold a memorial service for his mother. He did not attend.

For Discussion:

- Abuse of the elderly (physical abuse, financial abuse, and neglect) is an increasing problem in our society. What are your insights into why elderly people are abused?

- Imagine ways in which the church could contribute to the process of building positive relationships and of healing broken relationships in families of the elderly.

AIDS

We are often afraid of what we do not understand. Thus, throughout history, people have feared, avoided, and often despised the victims of diseases and conditions of which the causes and cures at the time have been known - leprosy, small-pox, the bubonic plague, polio, cerebral palsy, Down's syndrome, and cancer to name a few. Just as in biblical times the disciples asked Jesus, "Rabbi, who sinned, this man or his parents?" (John 9:2 RSV), people today often prefer to assign blame rather than to face in the sick and the dying the reality of their own mortality and their ultimate dependence upon God. Because many people believe that sexual activity is essentially sinful, this is particularly true of the victims of diseases which may be sexually transmitted. Today, the victims of AIDS struggle to fight their disease and to maintain their dignity in a society which is frequently more condemning than compassionate.

Story #7: One Man's Life

Adam, raised and resident in Regina, is living with AIDS. Handsome, youthful, witty, talented, and articulate, Adam is also very clear about AIDS and its effect on his life.

Adam realized that he had the HIV infection in 1981 when he started going to doctors for what he now recognizes as HIV-related illnesses. He tested HIV positive in the fall of 1984. Since then he has been AIDS symptomatic, with recurring bouts of flu, bronchial infections, and colds. Illness became more frequent in the fall of 1987 when Adam had the flu an average of once a week for eight weeks and had trouble keeping up with his job. He felt very uncomfortable at work, because he felt that he couldn't come out as a gay person, let alone as a person with HIV. He used a doctor's note saying he had a "viral illness" to explain his absenteeism. Adam stopped work in February 1988, and says, "that's when the trouble started."

Adam describes living with AIDS as an experience of "loss of control of life." "Your energy goes away from handling the money aspects of life into health concerns, but the bills keep piling up." Adam lived alone in his own home on which he was making monthly payments. His sick leave pay, 75% of his regular salary less deductions, left him with barely enough money to cover his mortgage, loan payments, and utilities, and with literally nothing for food, clothing, or entertainment. He says he felt like a hamster on a wheel trying to keep ahead of his financial obligations. Stress from the threat of losing his home contributed to more illness.

Adam gets angry thinking about visitors who stopped by to drink his coffee and to offer their shoulders to cry on. He wonders why those who cared didn't take him out for dinner or for a shopping trip to the local supermarket.

Getting permanently disability benefits was another trying experience. In order to receive benefits from his employer's ensurer, Adam had to waive the rights to his CPP disability plan. The process required a deluge of interviews and medical examinations and the completion of numerous forms, all of which are the client's responsibility. One of the biggest blocks was a doctor who, in the face of Adam's AIDS diagnosis, told him, "there's nothing I can do for you," but at the same time refused to sign the disability forms, saying Adam was well enough to work. Adam admits that there were days when this was true, but asks if an employer would keep him on with two or three sick days every week. Alone and sick, without the help of agencies or individuals, Adam found accessing the protection plans so stressful that at times it made him physically ill.

Adam has also found that his personal life has changed as a result of AIDS. People hold back from him and many have difficulty being affectionate. He says friends don't come up and hug him the way they did when he was not sick. Dating is limited to such activities as going to the movies; the possibility of forming an intimate relationship is precluded. Adam says he rationalizes rejection by attributing it to people's fear of death: "I am a mirror for their mortality." Although he has tried to look at his HIV infection as a natural phenomenon - illness - and to lead as normal a life as possible, he has found it too difficult to do so, and feels like removing himself from the whole world.

Adam acknowledges a lot of religious and spiritual needs as he comes to grips with AIDS in his life. He wonders who can help him find some answers. He wants to work out his feelings about himself and others. He has many questions about God and religion. "I questioned my religious upbringing and I rejected it." he says. "That leaves am empty space. If that isn't right, what is?"

Adam says he would welcome the presence of church people, but not all of them. He would reject those who would come to say, "It's obvious why you have this." He knows that there are ministers around who would be supportive and open to talking about religious questions with him, but says "We just haven't found each other."

For Discussion:

- Talk about some of the situations in our society in which we hold victims and their families to blame for their own misfortune. Share some of your insights as to why this happens. Is this just?

- Adam had difficulty accessing the pension plan to which he was entitled. Share the stories you know about people who have had similar experiences. Suggest ways in which such systems could be simplified or ways in which we could make it easier for people to cope with complicated systems.

- Adam has AIDS. Unless there are sudden miraculous advances in medical science, he will probably die soon. He is clear about his spiritual needs. Discuss ways in which we in the church can be present for Adam and minister to him in his time of need. Talk about the difficulties and hang-ups we have which get in the way of our ministering to him.

CHOICES TO MAKE

It is customary to think that ethical decisions regarding health care are individual life decisions. For example, should the life support system for a particular person be shut off or not. However, the amount of money allocated for health care in Canadian society is also an ethical decision, as is the distribution of this money between curative and preventative care.

Canadians should be asking some tough questions about health care and making thoughtful decisions regarding their health care system. For example: Should there continue to be such a heavy emphasis on high technology and hospital based care that focuses on curing illness and crisis management Or, should more money be spent on community-based illness prevention and health promotion care based on skills offered by a variety of health care professionals? In some places in Canada, a community-based health and social service centre staffed by various combinations of health care and social service professionals offers residents direct access to people who have the skills they need. First Lutheran Church of Vancouver is working towards beginning such a centre, called a Parish Care Centre.[35]

Canadians need to achieve a better balance in health care spending between prevention, care, cure, and rehabilitation so the money allocated to health care is used to best advantage. What would happen if we shifted spending in health care to an even fifty-fifty division between care to cure illness and prevention of illness? This is a hard question, because it is difficult to quantify prevention except by falling disease and accident rates.

Complicated factors make it difficult to know how to divide public money for health care wisely. Some people need care for long-term illness and will never get well, yet they deserve excellent care. Curing illness and saving lives of accident victims is immediately rewarding and is exciting news; on the other hand, rehabilitation is often a long, slow, lonely, individual struggle. It, too, is important. Funds must also

[35] Michael Nel, "The Parish Care Centre, A 'Whole Person' Approach to Health Care," The Pulse, 2, 1, Summer, 1987. p. 3.

be available for research in many areas, including the causes of particular diseases and disease prevention; ways of giving care; means of curing illness and of saving lives after accidents, and effective rehabilitation strategies.

Story #8: How Can This Be?

Harvey D. is twenty-five years old. Until last summer he had the world by the tail. He was strong, good-looking, and charming, well-liked by everyone in the farming community in which he lived. His ambition was to have the best dairy farm, the best herd of Holsteins in the province. He worked hard and he played hard. While it would be stretching it to say that he worshipped "hard", he did maintain ties to the ELCIC church in which he had been baptized and confirmed.

Then, last July, pushing it to try to be on time for a date to a social, he rolled his pick-up on a gravel road. He suffered multiple fractures and internal injuries, the worst being a severe head injury. He was rushed by ambulance to the general hospital in the large city 140 km. from his home, where he remains hospitalized, requiring acute care, more than a year later.

He has no movement below the neck. Though he is able to move his head slightly from side to side and blink his eyes, he cannot speak. He is still connected to monitors at the nursing station. Several times a day an alarm signals nurses and aides to rush in to drain collected fluid from his lungs and to get him breathing again.

Frequently he appears almost lucid; he seems to recognize nurses and members of his family. But, much of the time, although his eyes are open, he does not seem to be processing any information.

His mother drives in every day after work. A schedule has been worked out so that no evening brings fewer than three visitors, all of whom try to produce the spark that will rekindle the fire that once was Harvey D.

These devoted relatives and friends have decorated more than half of Harvey's semi-private room with anything and everything that might help to bring him back to awareness: large, biographical, hand-made posters complete with colour photographs, a ghetto blaster, a television, a baseball glove, stuffed toys, foil balloons, cards, flowers, and plants.

While the prognosis is not encouraging, no-one wants to give up, yet all the effort to regenerate this one life has cost not one, but two hospital beds. Because of the proliferation of paraphernalia, the constant state of semi-emergency, and the traffic, the second bed in the room is not suitable for use, except occasionally for the temporary accommodation of one who must stay overnight following minor surgery.

For Discussion:

- As Christians we hold life to be a sacred gift. Our advanced technology now sometimes puts us in a position where decisions about life and death are forced upon us. Imagine yourselves as members of Harvey's family. What supports do you need now? How can the church best serve you?

- What alternate care could be given Harvey? How can he be cared for in the best way Discuss the range of care services available in your community and consider what would ideally be available.

- De-institutionalization is currently being upheld as a way of saving health care money and automatically increasing life satisfaction for those needing care. Unfortunately, all too often people have been discharged from an institution without any preparation for their return to the community in the way of counselling supports, expanded home nursing programs, or even appropriate housing. Community care, or care outside of institutions, should not be seen as a way to save money but rather

as a way of spending health care money to more adequately meet individual and community health care needs.[36]

Health is more than a the absence of disease; it is the well-being of the whole individual and community. Recognition of this fact leads to questions about lifestyles and opportunities for living that enhance life satisfaction.

Story #9: Mousey's Story

Mousey M. is a fourteen-year-old native girl, one of a family of six from an isolated northern village. Because her family follows a trapline in winter and fishes out of the big lake whenever there is open water, her school attendance had been, at best, irregular.

Two years ago, to overcome this, the educational authorities arranged for Mousey to attend a boarding school in a small town 750 km. by air south of her home. She did not adapt well to this change. She became increasingly withdrawn and uncommunicative. Last fall, when she from her summer at home, she was downright uncooperative. Through the course of the school year, she erupted into several hostile outbursts aimed at both her teachers and her peers. She was the perpetrator of several acts of flagrant vandalism which culminated in a fortunately ill-conceived attempt at arson - she tried to burn down the school.

Psychological assessment revealed Mousey to be highly emotionally unstable, with sociopathic tendencies, exhibiting extremely inappropriate social interaction and an inability to cope with anger well.

A month ago, Mousey was transferred to a further 400 km. south to a treatment centre for emotionally disturbed adolescents in a city of 600,000, but to no avail. Her condition continues to deteriorate. Mousey has since twice tried to take her own life.

For Discussion:

- Well-meaning educational authorities imposed on Mousey what they considered to be an appropriate lifestyle for a fourteen-year-old girl. Discuss whether we as a society accept as appropriate lifestyles which differ from the norm.

- Are there factors which both you and Mousey could agree on as enhancing life satisfaction? What are they?

- Talk about ways that we might more adequately ensure that the systems of our society which are intended to bring justice don't inadvertently cause more harm than they do good.

- Share what you know about the Canada health care system as it concerns mental health and mental illness. Do we have sufficient numbers of trained health care workers in this field? Do we have adequate psychiatric facilities for youth For the elderly? For the criminally insane? How high a priority should this be?

More housing is needed for handicapped people and the elderly. These housing programs need to provide for individual apartments and full meal possibilities for people who are unable to cook for themselves or who prefer to socialize over a meal. The availability of a nurse within the building on a regular or twenty-four hours a day basis to assist with medications and treatments and to monitor chronic illnesses would

[36] Canadian Council on Social Development, "Proceedings of the Ottawa Conference: Improving the Delivery of Community-Based Health and Social Services." p. 7.

decrease the need for hospitalization and nursing home care.[37] Housing which provides for integrating handicapped and elderly persons with the able would provide opportunities for mutual sharing and increased life satisfaction, and would prevent marginalization.

More provincial funding is needed for community health care centres, which may also include readily available social services and leisure opportunities. These centres provide easy patient access to a variety of health care professionals and help reduce fragmentation of care. These centres and community nursing programs should be used not only to permit earlier release of people from hospital but also to minimize admissions to hospitals, in some cases avoiding hospitalization completely, something seldom done now.

What proportion of the tax dollar should go to direct health care? Governments have only as much money as taxpayers give them, and that money must provide for all the services needed by the population. Can the money already being spent make a larger contribution to the quality of the individual and community health? It should be recognized that other government expenditures also influence the health of the population; expenditures - such as those for affordable housing, good quality food, workplace safety and morale, protection of the environment, and provision of opportunities for culture and recreation - influence lifestyles, and thereby, health.

Canadians must become knowledgeable and active in promoting a health care system that will meet our future needs. The federal government should be lobbied to establish a Health Care Council of consumers and health care providers to monitor the health care system and make recommendations for improvements. The federal government should also re-establish the Canada Health Survey, to gather information about the health of Canadians and provide sound data on which to base decisions related to both health care and social policy. Both these actions have been recommended by the Canadian Nurses' Association and the Task Force on the Allocation of Health Care Resources.[38]

Provincial governments should be lobbied to try new ways of using health care funds so the skills of all health care providers are fully utilized, to best advantage and in the most cost-effective, appropriate setting.

Both levels of government should be commended for steps they have taken to reduce alcohol and tobacco advertising and to ban smoking in public places. Governments should be encouraged to continue these initiatives. In addition, they should use legislation and education to maintain nutritionally good and safe food for Canadians, to promote exercise and recreation, to provide good housing, to improve health and safety practices in the workplace and at home, and to protect the land, water, and air from pollution and destruction.

Responsibility For Action

In 1983, Dr. Krister Stendahl, now Bishop of Uppsala, speaking on The Theological Context of Health and Healing in the Lutheran Tradition and Experience, said: "In Mark's Gospel you can describe the whole ministry of Jesus as a pushing back of the frontier of all destructive and distorting forces. Healing bodies and minds ... is a mending of creation..."[39] The heritage of the Christian church - from the days of Constantine through the founding of Lutheran hospitals and health care institutions and agencies in North America - demonstrates that, when people act together responsibly, there is opportunity to achieve individual well-being as well as a common good.

[37] Task Force on the Allocation of Health Care Resources, p. 37.
[38] Canadian Nurses' Association, p. iii; and, Task Force on the Allocation of Health Care Resources, p. 125 and p. 130.

[39] Quoted by C. Monk in a recent sermon.

Others in Canadian society, including people in the federal government, health care providers, and consumer groups, are calling for a review and a rethinking of our health care system. These are complex matters and, as Christians, we have an important and creative role to play.

APPENDIX A

Monique Begin, in her new book, Medicare, Canada's Right to Health, describes her lonely battle to protect Medicare when, as Minister of National Health and Welfare, she piloted the Canada Health Act through Parliament. This Act, proclaimed April 1, 1984, was to end the practice of extra billing and user fees. She writes: "I was shocked at how fragile our seemingly solid social institutions are. Canadian medicare is one such institution.

The population often thinks that once an idea, a political program, or even a big collective project is created and established by legislation, and given money and human resources, it becomes an unchanging institution that just keeps rolling along. People think this true to Canadian health insurance." (Joan Cohen, "Begin Waged Lonely Battle For Medicare, Winnipeg Free Press, Thursday May 14, 1988 P. 7.)

We often forget that the federal government, the provinces and the medical profession are the chief actors presiding over our health care system, and they have the power to frustrate its operation and to change its nature. The Meech Lake Accord and the Free Trade Agreement between Canada and the U.S. enhance the possibilities to frustrate or to change negatively that system. Our health insurance programs are now more fragile and vulnerable than ever.

Today there is a movement which makes the marketplace, deregulation, privatization, and political decentralization the essence of its thrust. There may or may not be a hidden agenda. However, we can assume that the people, who are already exerting pressure to have more money directed to the "bottom line" and less to social programs, must be secretly delighted to see the possibility of doing through the Meech Lake Accord and the Free Trade Agreement what they could not do openly through the political process. National collective decision-making for the common good may no longer be a concern. More and more the deciding factor is a value judgement based on economic determinism rather than the common good, i.e., serving equitably the basic needs of all Canadians.

It is said that Medicare would never have happened if, at the time, the Meech Lake Accord had been in place. Will it be possible again to do anything innovative relative to Medicare and other insured health services? Can Canadians anticipate national standards for such services any longer? Or will they have to be satisfied with "national objectives," vaguely defined and probably difficult to implement? Will Canadians in whatever province have a sense of being equal with respect to health care or will there be a balkanization of our health care system Is it possible that the federal government will distance itself from Medicare and other insured health services, a seeming trend since 1977? What will it do if any province diminishes or challenges aspects of health care delivery? Has the federal government, by initiating the Meech Lake Accord, abdicated its power to assure all Canadians equity in their health care system?

The federal government and other proponents of the Free Trade Agreement are asking Canadians to take a "leap of faith." However, with the exception of some projected economic benefits, we have little information. The government has been less than frank in telling Canadians about the minus factors. The reality is that Canadians are being asked to take a leap of naivety. Who, for instance, can predict the long-term implications for health care? On the one hand, the changes could be subtle and irreversible. In a few years we could wake up to discover that our health care system has been irreparably damaged. On the other hand, the changes may be far from subtle. Some feel that the Meech Lake Accord and the Free Trade Agreement will eventually be seen as the watersheds of the century with respect to our social programs.

We have been told that social programs are safe because they are not mentioned in the Agreement. Not so. The only services completely exempted are child welfare and child care. Why the silence on health

care programs? It appears that social programs not specifically mentioned are not thereby protected but instead are subject to the trade agreement. Hence there is no assurance that a social program, such as Medicare or hospital insurance, which provides a degree of government financing not existent on the American side, will not be subject to direct challenge.

Canada failed to win American assurances that Canadian social programs would not be treated as trade-distorting subsidies. That puts present and future programs in question. Negotiations to resolve the issue of subsidies are to continue for up to seven years. Who would dare to predict the outcome of that process? Furthermore, would Washington want to approve any new program?

When it comes to harmonizing trade distortions, the trend will likely be towards the lowest common denominator. Americans think programs like Medicare are subsidies. We are dealing with a trading partner that believes the American way is the best way. The American psyche is so imbued by what it has internalized, namely, that state intervention is by definition bad and that market forces are by definition good. It does not seem to matter that such forces have resulted in a more expensive and less efficient health care system. While it is unclear as to what extent Canadian laws will be subservient to the Free Trade Agreement, it is clear that the Agreement will be subservient to U.S. law. Is Canada likely to win if Medicare, for instance, is construed as a subsidy and taken before a bi-national tribunal?

Another risk to health care inherent in the Free Trade Agreement is the stance of some associations representing business and industry. They are already on record that competition will mean imposing on Canada the same conditions as exist in the U.S. Hence there will be market pressure for reduction in social programs, or even their elimination. If a business or industry is targeted for countervailing action because of a subsidy in the health care field, one can anticipate a flurry of lobbying in Ottawa and the provincial capitals.

Under the "national treatment" provision of the Free Trade Agreement, American firms must be given treatment equal to Canadians in the management of a broad range of health services such as hospitals (general, rehabilitation, extended care, psychiatric), ambulance services, home care, nursing care homes, public health clinics, laboratories, and blood banks. Apparently, the Canadian government waived legislative options which could ensure that any health care service would correspond to existing principles. One of the pillars for the Medical Care act of 1966 was the principle that insured health services should be administered on a non-profit basis by a public authority in each province.

Thus Canada is leaving itself open to increasing privatization. That could result in Canada having two health care systems - a private one for those with good incomes and a public one, poorly financed, for those with lower incomes. Privatization, it is said, does not increase the availability of resources. It simply diverts more of those resources to people with the ability to pay. That could mean Canada reverting to an unjust health care system.

Terrance Hunsley, Executive Director of the Canadian Council on Social Development, in an article sin the Winnipeg Free Press (Friday, July 19, 1988 p. 7) concludes: "We are faced with more questions than answers in exploring the social implications of free trade. But they are questions which deserve answers, especially as our national economy becomes but a small corner of a new international order, and as leadership in social programs is pushed from the national to provincial and local governments, and to the private market. The proposed Free Trade Agreement underscores the need for a clear expression of the place of social policy in a changing nation."

Some people may feel that the element of risk to our health care system is being overstated. If so, let them answer two critical questions which are cause for much concern for other people: Will we in Canada have enough resolve to pursue an independent course to uphold our social values? Will our political will be strong enough?